30-765 COST LIMITATIONS 30-765

.1 The following limitations shall apply to all payments made for in-home supportive services:

.11 The maximum services authorized per month except as provided in Section 30-765.3, under IHSS to any recipient determined to be severely impaired, as defined in Section 30-753(s)(1) shall be that specified in Welfare and Institutions Code Section 12303.4(b) or as otherwise provided by law.

HANDBOOK BEGINS HERE

.111 The IHSS service hours for a severely impaired recipient receiving services through the individual provider mode of delivery shall not exceed 283 hours per month effective July 8, 1988. (Welfare and Institutions Code Section 12303.4(b)(1)).

.112 The IHSS payment maximums for a severely impaired recipient receiving services in modes of delivery other than the individual provider mode shall not exceed $1,202.75 per month, effective July 8, 1988. (Welfare and Institutions Code Section 12303.4(b)(2)).

.113 Welfare and Institutions Code Section 12300(g)(2) states:

"Any recipient receiving services under both Section 14132.95 and this article shall receive no more than 283 hours of service per month, combined, and any recipient of services under this article shall receive no more than the applicable maximum specified in Section 12303.4." (See Section 30-765.11.)

HANDBOOK ENDS HERE

.12 The maximum services authorized per month except as provided in Section 30-765.3, under non-PCSP to any recipient determined not to be severely impaired shall be that specified in Welfare and Institutions Code Section 12303.4(a) or as otherwise provided by law.

HANDBOOK BEGINS HERE

.121 The IHSS service hours for a recipient who is not determined to be severely impaired and receives services through the individual provider mode of service delivery shall not exceed 195 hours per month effective July 8, 1988 (Welfare and Institutions Code Section 12303.4(a)(1)).

.122 The IHSS payment maximum for a nonseverely impaired recipient receiving services through modes of delivery other than the individual provider mode shall not exceed $828.75 per month, effective July 8, 1988. (Welfare and Institutions Code Section 12303.4(a)(2)).

HANDBOOK ENDS HERE

30-765 COST LIMITATIONS (Continued) **30-765**

.13 The statutory maximum service hours per month shall be inclusive of any payment by IHSS for a restaurant meal allowance established in accordance with the Welfare and Institutions Code Section 12303.7.

.131 The statutory maximum for individuals receiving services through the individual provider mode of service delivery and eligible for the restaurant meal allowance shall be determined by multiplying the statutory maximum hours of service by the county wage rate, subtracting the restaurant meal allowance (see Section 30-757.134(a)(1)(A)) from this product and dividing the remainder by the county hourly wage rate.

.132 The statutory maximum for individuals receiving services through modes of delivery other than the individual provider mode shall be determined by subtracting the restaurant meal allowance (see Section 30-757.134(a)(1)(A)) from the payment maximum ($1,202.75 for the severely impaired and $828.75 for the nonseverely impaired) and dividing this by the county hourly wage rate.

.14 The county shall not make monthly payments of IHSS monies to recipients in excess of the computed maximums in Sections 30-765.11, .12 and .13. The sum of the IHSS monthly payment and the recipient's share of cost, if any, shall not exceed the appropriate maximum.

.2 The statewide wage rate for individual providers shall be determined by the Department. Effective July 8, 1988, the statewide wage rate is $4.25.

HANDBOOK BEGINS HERE

.21 DHS regulation Section 51535.2 reads:

Reimbursement Rates for Personal Care Services Program.

(a) For the individual provider mode for providing personal care services, the reimbursement rate shall be a maximum of $5.50 per hour of service: provided, however, that the reimbursement rate in each county shall not exceed the rate in each county for the individual provider mode of service in the IHSS program pursuant to Article 7 (commencing with Section 12300) of Part 3 of Division 9 of the Welfare and Institutions Code, as it existed on September 28, 1992.

HANDBOOK CONTINUES

30-765 COST LIMITATIONS (Continued) **30-765**

HANDBOOK CONTINUES

(b) For the contract mode for providing personal care services pursuant to Welfare and Institutions Code Sections 12302 and 12302.1, the reimbursement rates shall be those specified in the contract between the county and the agency contractor not to exceed the following maximum rates for services provided through State fiscal year 1993-1994 as follows:

(1)	Butte	$ 9.65
(2)	Nevada	$10.34
(3)	Riverside	$12.29
(4)	San Diego	$10.49
(5)	San Francisco	$12.28
(6)	San Joaquin	$ 9.50
(7)	San Mateo	$12.65
(8)	Santa Barbara	$11.76
(9)	Santa Clara	$11.11
(10)	Santa Cruz	$13.61
(11)	Stanislaus	$10.51
(12)	Tehama	$11.30
(13)	Ventura	$11.04

(c) Nothing in this section is intended to be a limitation on the rights of providers and beneficiaries or on the duties of the Department of Social Services, pursuant to Welfare and Institutions Code Section 12302.2 subdivision (a). Contributions, premiums and taxes paid pursuant to Welfare and Institutions Code Section 12302.2, subdivision (a) shall be in addition to the hourly rates specified in subdivision (a) of this section.

HANDBOOK ENDS HERE

30-765 COST LIMITATIONS (Continued) **30-765**

.3 IHSS recipients receiving services through the individual provider mode of delivery shall not receive less service hours per month than he/she received during June 1988, without a reassessment of need. The reassessment shall not result in an automatic reduction in authorized hours, unless the recipient no longer needs the hours.

.4 These regulations shall remain in effect until July 1, 1990, unless a later enacted regulation extends or repeals that date.

NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Sections 12300 and 14132.95, Welfare and Institutions Code.

30-766 COUNTY PLANS 30-766

.1 Each county welfare department shall develop and submit a county plan to CDSS no later than 30 days following receipt of its allocation, which specifies the means by which IHSS will be provided in order to meet the objectives and conditions of the program within its allocation.

.11 The plan shall be submitted to CDSS and shall be based upon relevant information, as specified in Welfare and Institutions Code Sections 12301 and 14132.95, including, but not limited to the information specified below:

.111 Projected caseload, hours paid, and costs per month/quarter by mode;

.112 Modes of IHSS and PCSP service delivery the county intends to use;

.113 Estimated program costs for both the IHSS and PCSP programs;

.114 Methods the county will utilize to control non-PCSP program costs to comply with required fiscal limitations; and

.115 Program design intended to meet PCSP requirements.

.12 County plans and amendments shall be effective upon submission.

.13 CDSS shall review each county plan for compliance with Welfare and Institutions Code Sections 12300, et seq. and 14132.95, regulations of CDSS and DHS, and when appropriate, issue departmental approval.

.131 CDSS, when appropriate, shall adjust funding levels contained in the plan, as a condition of approval.

.132 A county plan which includes IHSS administrative costs shall not be issued departmental approval.

.133 If, after review, CDSS determines that a county plan is not in compliance, the Department shall require the county to amend its plan.

.134 CDSS shall develop a county plan for counties which have not submitted plans within the required time frame, based on CDSS' estimate for those counties. Such plans shall be effective upon written notification to the county.

30-766 COUNTY PLANS (Continued) **30-766**

.14 In the event that funds are available for reallocation, special consideration shall be given to those counties which submit their county plans by the due date.

.141 CDSS shall be permitted to reallocate funds from counties which are late based on CDSS's estimate for those counties.

.15 Each county shall monitor its expenditures monthly. Upon discovery by either CDSS or the county that anticipated expenditures will exceed the amount of the county's base allocation, the county shall immediately submit to CDSS for approval an amended plan.

.151 Repealed by CDSS Manual Letter No. SS-90-02, effective 10/4/90.

.152 Repealed by CDSS Manual Letter No. SS-90-02, effective 10/4/90.

.16 Counties shall not reduce authorized services or hours of service to recipients in order to remain within their allocation.

.17 All state-mandated program costs, after the required county contribution, shall be eligible for reimbursement from state social service funds. If appropriated funds are insufficient to reimburse counties for all state-mandated costs, the state shall fully reimburse the counties for all state-mandated program costs, less the required county contribution.

.18 The portion of county expenditures which, after the county contribution, exceeds the allocation, shall not be eligible for reimbursement from state social service funds if such deficit is caused by:

.181 Noncompliance with the requirements of the state-approved county plan or State allocation plan; or

.182 Non-state-mandated costs; or

.183 IHSS administrative costs.

30-766 COUNTY PLANS (Continued) **30-766**

HANDBOOK BEGINS HERE

(a) Some examples of situations where reimbursement would not be made are:

(1) A county chooses to give a wage/benefit increase to IHSS providers which is higher than that provided in the Budget Act; or

(2) A county chooses to expand its use of a more expensive service delivery mode beyond the level of caseload and hours growth for each mode that is built into the Budget Act; or

(3) A county chooses to enter into a third party contract at an hourly rate higher than the maximum established for that county; or

(4) A county chooses to shift to a more expensive mode without providing for noncomitant offsetting savings in other areas, and causing a cost overrun.

HANDBOOK ENDS HERE

NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; Chapter 939, Statutes of 1992. Reference: Sections 10102, 12301, 12302, 12306, 12308, 13002, and 14132.95, Welfare and Institutions Code; and Chapter 93, Statutes of 1989 (Budget Act of 1989).

30-767 SERVICE DELIVERY METHODS 30-767

.1 The county shall arrange for the provision of IHSS through one or more of the methods specified below in accordance with an approved county plan:

HANDBOOK BEGINS HERE

Counties may choose modes of delivery that best meet the needs of their recipient population in their county demographic situation (WIC 12302). However, state reimbursement can be available only within the constraints imposed by the annual budget act (WIC 12300) and state allocation plan (WIC 10102), all of which must be reflected in state-approved individual county plans. Counties which exceed the constraints run the risk of not receiving full reimbursement if the cost overrun was due to non-state mandated costs, i.e., costs within county control, or more expensive modes used beyond amounts approved in an individual county plan.

HANDBOOK ENDS HERE

30-767 SERVICE DELIVERY METHODS (Continued) **30-767**

.11 County Employment.

.111 The county shall be permitted to hire service providers in accordance with established county civil service requirements or merit system requirements. The county shall be permitted to consider such providers as temporary employees if approved by the appropriate civil service system.

.112 The county shall insure that each service provider is capable of and is providing the services authorized.

.12 Purchase of Service from an Agency.

.121 The county may contract with an agency to provide service in accordance with the requirements of Division 10 and 23. The contract shall include a provision requiring the contractor to maintain a listing of contract recipients, their authorized hours, service hours provided and the amount paid for those services to the contract agency.

.122 The county shall insure that the contractor guarantees the continuity and reliability of service to recipients, supervision of service providers, that each service provider is capable of and is providing the service authorized and complies with the requirements of Division 21 (Civil Rights).

.123 The county shall insure that preference is given to the selection of providers who are recipients of public assistance or other low-income persons who would qualify for public assistance in the absence of such employment, except in regard to persons recruited by the recipient.

.13 Purchase of Service From An Individual.

.131 The county shall make payment under this delivery method through the payrolling system as described in Section 30-769.

.132 The county shall make a reasonable effort to assist the recipient to obtain a service provider when the recipient is unable to obtain one individually.

30-767 SERVICE DELIVERY METHODS (Continued) **30-767**

.133 The county shall have the right to change from one to another of the three delivery methods outlined above or from payment in advance to payment in arrears when any of the following apply:

(a) It has been determined that a recipient is using his/her payment for other than the purchase of authorized services.

(b) The recipient has failed to submit time sheets, as specified in Section 30-769.737 within 90 days from the date of payment.

(c) The recipient has not provided timely payment to his/her providers.

.2 Counties may elect to contract with a nonprofit consortium or may create a public authority to provide for the delivery of IHSS.

.21 The board of supervisors shall establish a public authority by ordinance.

.211 The public authority shall be separate from the county. Employees of the public authority shall not be considered to be employees of the county for any purpose.

.212 The ordinance shall designate the governing body of the public authority and specify the qualifications of the individual members, the procedures for nomination, selection, appointment, tenure and removal of members, and such other matters as the board of supervisors deems necessary for the operation of the public authority.

(a) The board of supervisors may designate itself as the governing body of the public authority.

(1) If the board of supervisors is the governing body, the ordinance shall require the appointment of an advisory committee of no more than 11 members.

(2) No fewer than 50 percent of the advisory committee shall be consumers as defined in Manual of Policies and Procedures Section 30-753(c)(1).

(b) If the board of supervisors does not designate itself the governing body of the public authority, it shall specify by ordinance the membership of the governing body of the public authority.

30-767 SERVICE DELIVERY METHODS (Continued) **30-767**

(1) No fewer than 50 percent of the members of the governing body shall be consumers as defined in Manual of Policies and Procedures Section 30-753(c)(1).

.213 Before appointing members to the governing body or advisory committee, the board of supervisors shall solicit recommendations from the general public and interested persons and organizations through a fair and open process which includes reasonable written notice and a reasonable time to respond.

(a) The provisions at Section 30-767.213 shall be met by satisfying the requirements governing legislative bodies outlined in Government Code and other state and federal law, including, but not limited to, the Ralph M. Brown Act (Government Code Section 54950 et seq.) and the Americans with Disabilities Act.

.214 Prior to initiating delivery of IHSS through a public authority, the county shall enter an agreement with the public authority specifying the purposes, scope or nature of the agreement, the roles and responsibilities of each party including provisions which ensure compliance with all applicable state and federal labor laws, and compliance with all statutory and regulatory provisions applicable to the delivery of IHSS. This agreement shall also specify the fiscal provisions under which the public authority shall be reimbursed for its performance under the agreement. The county, in exercising its option to establish a public authority, shall not be subject to competitive bidding requirements.

.215 Prior to initiating the delivery of IHSS through a public authority, the county shall submit to the California Department of Social Services a copy of the agreement as specified in Section 30-767.214 along with the following information concerning the public authority:

(a) Organization chart of the public authority.

(b) Funding provision for public authority costs, including how the proposed rate was developed.

(1) The rate development process and the public authority hourly rate must be approved by Department of Health Services prior to initiating the delivery of services.

(c) Public authority staffing classifications and duties.

(d) A description of how the functional requirements of Welfare and Institutions Code Section 12301.6(e) will be met.

30-767 SERVICE DELIVERY METHODS (Continued) **30-767**

HANDBOOK BEGINS HERE

(e) The requirements of Welfare and Institutions Code Section 12301.6(e) are listed in Section 30-767.23.

HANDBOOK ENDS HERE

.216 If the public authority contracts with another entity to provide the delivery of IHSS, the agreement shall satisfy the requirements of Manual of Policies and Procedures Chapter 23-600 relating to contracting.

.217 All costs claimed for the delivery of services under an agreement as specified in Section 30-767.214 shall be claimed in compliance with criteria for rate setting found at Section F, attachment 4.19-B of the California Medicaid State Plan.

(a) A county shall use county-only funds to fund both the county share and the state share of any increase in the cost of the program, including employment taxes, due to any increase in provider wages or benefits negotiated or agreed to by a public authority or nonprofit consortium unless otherwise provided for in the annual budget act or appropriated by statute. No increase in wages or benefits negotiated or agreed to pursuant to this section shall take effect until the Department has obtained the approval of the State Department of Health Services.

.22 A county may contract with a consortium for delivery of services.

.221 A consortium entering a contract under Section 30-767.22 shall have a governing body composed as described in Section 30-767.212(b)(1), or shall have established an advisory committee composed as described in Sections 30-767.212(a)(1) and (2).

.222 Such contracts shall be subject to the provisions of Manual of Policies and Procedures Chapter 23-600.

.223 A consortium entering a contract under Section 30-767.22 shall be deemed to be the employer of IHSS personnel referred to recipients as described in Section 30-767.23 for the purposes of collective bargaining over wages, hours and other terms and conditions of employment.

.23 Any public authority or consortium shall provide the following minimum services:

30-767 SERVICE DELIVERY METHODS (Continued) **30-767**

.231 Provide registry services to recipients receiving services pursuant to Section 30-767.23.

(a) Assistance in finding providers through the establishment of a registry.

(b) Investigation of the qualifications and background of potential providers listed on the registry.

(c) Establishment of a referral system under which potential providers are made known to recipients.

.232 Provide access to training for providers and recipients.

HANDBOOK BEGINS HERE

(a) Access to training for providers and recipients does not mean that the county or the Public Authority is under any obligation:

(1) to provide the training directly, to pay for training provided in the community, to pay for the provider's time to attend or to accompany the recipient to training, to pay for transportation to the training, or to pay for any materials required by the training; or

(2) to screen or be responsible for the content of any training it tells providers and/or recipients is available in the community; or

(3) to ensure that any provider or recipient attended/completed any training.

HANDBOOK ENDS HERE

.233 Perform any other function related to the delivery of IHSS.

.234 Ensure that the requirements of the Personal Care Services Program pursuant to Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code are met.

.24 Any public authority may adopt reasonable rules and regulations for the administration of employer-employee relations.

30-767 SERVICE DELIVERY METHODS (Continued) **30-767**

HANDBOOK BEGINS HERE

.241 The Employer-Employee Relations Policy for Public Authorities Delivering In-Home Supportive Services is available from the California Department of Social Services as a model for public authorities. Public authorities may adopt, reject, or modify the policy in part or in its entirety.

HANDBOOK ENDS HERE

.25 Public authorities and consortia must submit cost reports and such other data as required for the Case Management, Information and Payrolling System (CMIPS).

.26 Any county that elects to provide for in-home supportive services pursuant to this section shall be responsible for any increased costs to the CMIPS attributable to such election. The Department shall collaborate with any county that elects to provide in-home supportive services pursuant to this section prior to implementing the amount of financial obligation for which the county shall be responsible.

.3 No recipient of any services specified in Section 30-757.14 or .19 shall be compelled to accept services from any specific individual, except for individuals recruited by the recipient's guardian, conservator, or, in the case of recipients who are minors, by their parents.

.31 For those recipients who are receiving services through the delivery methods described in .11 and .12 above, hiring preference shall be given to qualified persons recruited by the recipient to deliver services. For the purpose of this section a qualified person is one who meets the minimum requirements established by the contract agency or the County Civil Service or Merit Systems.

HANDBOOK BEGINS HERE

.4 Personal Care Services Program Providers

DHS regulation Section 51181 reads:

Personal Care Services Provider.

A personal care services provider is that individual, county employee, or county contracted agency authorized by the Department of Health Services to provide personal care services to eligible beneficiaries. An individual provider shall not be a family member, which for purposes of this section means the parent of a minor child or a spouse.

HANDBOOK CONTINUES

30-767 SERVICE DELIVERY METHODS (Continued) **30-767**

HANDBOOK BEGINS HERE

.5 Personal Care Services Program Provider Enrollment

DHS regulation Section 51204 reads:

Personal Care Services Provider.

All providers of personal care program services must be approved by Department of Health Services and shall sign the "Personal Care Program Provider/Enrollment Agreement" form [SOC 426 1/93)] designated by the Department agreeing to comply with all applicable laws and regulations governing Medi-Cal and the providing of personal care service. Beneficiaries shall be given a choice of service providers.

(a) Individual providers will be selected by the beneficiary, by the personal representative of the beneficiary, or in the case of a minor, the legal parent or guardian. The beneficiary or the beneficiary's personal representative, or in the case of a minor, the legal parent or guardian shall certify on the provider enrollment document that the provider, in the opinion of the beneficiary, is qualified to provide personal care so long as the person signing is not the provider.

(b) Contract agency personal care providers shall be selected in accordance with Welfare and Institutions Code Section 12302.1. The contract agency shall certify to the designated county department that the workers it employs are qualified to provide the personal care services authorized.

.6 Provider Audit Appeals

DHS regulation Section 51015.2 reads:

Providers of Personal Care Services Grievance and Complaints.

Notwithstanding Section 51015, when a provider of personal care services has a grievance or complaint concerning the processing or payment of money for services rendered, the following procedures must be met:

(a) The provider shall initiate an appeal, by submitting a grievance or complaint in writing, within 90 days of the action precipitating the grievance or complaint, to the designated county department identifying the claims involved and specifically describing the disputed action or inaction regarding such claims.

HANDBOOK CONTINUES

30-767 SERVICE DELIVERY METHODS (Continued) **30-767**

HANDBOOK CONTINUES

(b) The designated county department shall acknowledge the written grievance or complaint within 15 days of its receipt.

(c) The designated county department shall review the merits of the grievance or complaint and send a written decision of its conclusion and reasons to the provider within 30 days of the acknowledgment of the receipt of the grievance or complaint.

(d) After following this procedure, a provider who is not satisfied with the decision by the designated county department may seek appropriate judicial remedies in compliance with Section 14104.5 of the Welfare and Institutions Code, no later than one year after receiving notice of the decision.

HANDBOOK ENDS HERE

NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Sections 12301.6, 12302, 12302.1, and 14132.95, Welfare and Institutions Code and Section 54950 et seq., Government Code.

30-768 OVERPAYMENTS/UNDERPAYMENTS 30-768

.1 Definition of Overpayment for Non-PCSP Payments

.11 Overpayment means that cash payment was made for the purchase of IHSS or services were delivered in an amount to which the recipient was not entitled.

.111 Services payments paid pending a state hearing decision as required by MPP 22-022.5 are not overpayments and cannot be recovered.

30-768 OVERPAYMENTS/UNDERPAYMENTS (Continued) **30-768**

.2 Amount of Overpayment for Non-PCSP Payments

When the county has determined that an overpayment has occurred, the county shall calculate the amount of overpayment as follows:

.21 Overpayment due to the recipient's failure to use total direct advance payment for the purchase of authorized hours.

.211 Authorization based on an hourly rate

a. Determine the number of service hours for which the recipient received a direct advance payment in excess of those service hours actually paid for.

b. Multiply this amount by the hourly wage rate used in computing the recipient's authorized payment.

.212 Authorization for a personal attendant

When services are delivered by a personal attendant, the amount of the overpayment is the difference between the amount that should have been paid and the amount which was actually paid.

.213 When the recipient receives a direct advance payment to purchase services in a given month, but fails to submit a reconciling time sheet within 45 days from the date of payment, there is a rebuttable presumption that the unreconciled amount is an overpayment.

.22 Overpayment due to excess service authorization

.221 Authorization based on an hourly rate

a. Determine the number of service hours for which payment was made in excess of the correct service authorization.

b. Multiply this amount by the county's lowest individual provider hourly wage rate regardless of the service delivery method used.

.222 Authorization for a personal attendant

When services are delivered by a personal attendant, the amount of overpayment is the difference between the amount paid and the amount which would have been paid if the service authorization was correct.

30-768 OVERPAYMENTS/UNDERPAYMENTS (Continued) **30-768**

.23 Overpayment due to incorrect share of cost

Where the correct share of cost was more than the recipient paid, the resulting overpayment is determined by subtracting the amount paid from the correct amount.

.24 Overpayment due to nonpayment of share of cost

Where the service hours were provided to the recipient, but he/she did not pay his/her obligated share of cost, the county should initiate overpayment recovery for the entire amount of the IHSS payment for the month in which the recipient was ineligible.

.25 Overpayment due to nonexpenditure of restaurant meal allowance

Where the recipient received an allowance for the purchase of restaurant meals, and used none of the allowance for that purpose, or if the recipient was ineligible for a restaurant meal allowance he/she received, the entire amount is an overpayment.

.3 Recovery of Overpayments for Non-PCSP Payments

.31 Limitations on amount of Recovery

.311 The repayment liability of the recipient shall be limited to the amount of liquid resources and income excluded or disregarded by the SSI/SSP Program. Liquid resources are cash or financial instruments that can be converted to cash, except funds set aside for burial.

.312 When an overpayment results from the recipient's failure to spend the entire amount of an advance direct payment for the purchase of authorized services, the difference in value between the hours purchased and the hours authorized shall be considered an available resource in determining repayment liability.

.32 Methods of Recovery

.321 The county may recover overpayments using any one or a combination of the methods listed below.

(a) Balancing

(1) Balancing means recovery of all or a portion of an overpayment by applying a repayable underpayment against it.

30-768 OVERPAYMENTS/UNDERPAYMENTS (Continued) **30-768**

(2) An underpayment shall not be balanced against an overpayment if the underpayment is discovered and payable prior to the time an overpayment is discovered and adjustable.

(b) Payment Adjustment

(1) Payment adjustment means that the county reduces payment for future authorized services to offset an overpayment.

(2) If the service payment is reduced to adjust for previous overpayments, the recipient shall be responsible for paying the current month's adjustment amount to the service provider in addition to any share of cost.

(c) Voluntary Cash Recovery

(1) Voluntary cash recovery means repayment voluntarily made to the county by a recipient who has incurred an overpayment.

(2) The recipient shall be given the option of voluntary cash repayment of all or a part of the amount to be adjusted in lieu of payment adjustment.

(d) Civil Judgment

The county shall have the authority to demand repayment and file suit for restitution for any unadjusted portion of an overpayment.

.33 Notice of Action

If the county determines that an overpayment has occurred as defined in .11 above and proposes to recover the overpayment, the county shall notify the recipient of the following:

.341 The period of time during which the overpayment occurred.

.342 The reason for the overpayment.

.343 The amount of overpayment and a description of how the amount was calculated.

.344 The method by which the county proposes to recover the overpayment.

.4 Definition of Underpayment for Non-PCSP Payments

.41 Underpayment means the recipient was entitled to more service than was authorized or that the share of cost paid by the recipient was greater than the correct amount.

30-768 OVERPAYMENTS/UNDERPAYMENTS (Continued) **30-768**

.411 An underpayment has occurred when the county has failed to determine the correct share of cost or authorize the correct amount of service when all essential information was available to the county.

.412 An underpayment has not occurred when there is a disagreement in the county's exercise of discretion or opinion, where discretion or opinion is allowed in the determination of the need for service.

.42 Amount of Underpayment

When the county has determined that an underpayment has occurred, the county shall calculate the underpayment as follows:

.421 Incorrect Service Authorization

(a) Subtract the number of hours actually authorized from the number of hours to which the recipient was entitled.

(b) Multiply this amount by the county's lowest individual provider hourly wage rate regardless of the service delivery method used.

.422 Share of Cost

When the correct share of cost was less than the recipient paid, the resulting underpayment is determined by subtracting the correct amount from the amount paid.

.423 Restaurant Meals

When the amount paid was less than the amount to which there was entitlement, subtract the amount paid from the correct amount.

.43 Method of Payment

.431 Underpayments shall be adjusted by an increase in the service authorization when the unauthorized service for which there was entitlement was yard hazard abatement or heavy cleaning, and the service was not previously provided through another source at no cost to the recipient.

.432 All other underpayments shall be corrected by a retroactive payment issued to the recipient in an amount equal to that of the calculated underpayment.

30-768 OVERPAYMENTS/UNDERPAYMENTS (Continued) **30-768**

.44 Notice of Action

If the county determines that an underpayment has occurred as defined in .4 above, the county shall notify the recipient of the following:

.441 The time period during which the underpayment occurred.

.442 The reason for the underpayment.

.443 The amount of the underpayment, and a description of how the amount was calculated.

.444 The method by which the county proposes to adjust the underpayment.

HANDBOOK BEGINS HERE

.5 DHS regulation Section 50781 reads:

Potential Overpayments

(a) A potential overpayment occurs when any of the following conditions exist, as limited by (c).

(1) A beneficiary has property in excess of the property limits for an entire calendar month.

(2) A beneficiary or the person acting on the beneficiary's behalf willfully fails to report facts and those facts, when considered in conjunction with the other information available on the beneficiary's circumstances, would result in ineligibility or an increased share of cost.

(3) A beneficiary has other health coverage of a type designated by the Department [of Health Services] as not subject to post-service reimbursement, and the beneficiary or the person acting on the beneficiary's behalf willfully fails to report such coverage.

HANDBOOK CONTINUES

30-768 OVERPAYMENTS/UNDERPAYMENTS (Continued) **30-768**

HANDBOOK CONTINUES

(b) A beneficiary of the person acting on the beneficiary's behalf willfully fails to report facts if he/she has completed and signed a Medi-Cal Responsibilities Checklist, form MC 217, and a Statement of Facts and has, within his/her competence, done any of the following:

(1) Provided incorrect oral or written information.

(2) Failed to provide information which would affect the eligibility or share of cost determination.

(3) Failed to report changes in circumstances which would affect eligibility or share of cost within 10 days of the change.

(c) If a change occurred in a person's circumstances and that change could not have been reflected in the person's eligibility determination for the month in which the change occurred or the month following because of the 10 day notice requirements specified in Section 50179, no potential overpayment exists in that month or in the following month if appropriate.

.6 DHS regulation Section 50786 reads:

Action on Overpayment -- Department of Health Services or County Unit Contracted to Collect Overpayments

(a) Upon receipt of a potential overpayment referral, the Department's Recovery Section or the county unit contracted to collect overpayments shall:

(1) Determine the amount of Medi-Cal benefits received by the beneficiary for the period in which there was a potential overpayment.

(2) Compute the actual overpayment in accordance with the following:

(A) When the potential overpayment was due to excess property, the actual overpayment shall be the lesser of the:

HANDBOOK CONTINUES

30-768 OVERPAYMENTS/UNDERPAYMENTS (Continued) **30-768**

HANDBOOK CONTINUES

1. Actual cost of services paid by the Department during that period of consecutive months in which there was excess property throughout each month.

2. Amount of property in excess of the property limit during that period of consecutive months in which there was excess property throughout each month. This excess amount shall be determined as follows:

   a. Compute the excess property at the lowest point in the month for each month.

   b. The highest amount determined in a. shall be the amount of the excess property for the entire period of consecutive months.

(B) When the potential overpayment was due to increased share of cost, the actual overpayment shall be the lesser of the:

1. Actual cost of services received in the share of cost period which were paid by the Department.

2. Amount of the increased share of cost for the share of cost period(s).

(C) When the overpayment was due to excess property and increased share of cost, the actual overpayment shall be a combination of (A) and (B).

(D) When the potential overpayment was due to other factors which result in ineligibility the overpayment shall be the actual cost of services paid by the Department.

HANDBOOK CONTINUES

30-768 OVERPAYMENTS/UNDERPAYMENTS (Continued) **30-768**

HANDBOOK CONTINUES

(E) Potential overpayments, due to beneficiary possession of other health coverage that is not subject to post-service reimbursement, shall be processed by the Department to determine and recover actual overpayments in all cases. The actual overpayment in such cases shall be the actual cost of services paid by the Department which would have been covered by a private health insurance or other health coverage, had the coverage been known to the Department. The actual overpayment shall not include any costs which can be recovered directly by the Department from the health insurance carrier or other source.

(3) Refer those cases where there appears there may be fraud to the Investigations Branch of the Department.

(4) Take appropriate action to collect overpayments in accordance with Section 50787.

.7 DHS regulation Section 50787 reads:

Demand for repayment

(a) The Department or the county unit contracted to collect overpayments shall demand repayment or actual overpayments in accordance with procedures established by the Department.

(b) The Department or the county unit contracted to collect overpayments may take other collection actions as permitted under state law.

HANDBOOK ENDS HERE

NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Sections 10554, 12304.5 and 14132.95, Welfare and Institutions Code.

30-769 PAYROLLING FOR INDIVIDUAL PROVIDERS 30-769

.1 This section governs the procedures that shall be followed by counties making payments under the delivery method specified in Section 30-767.13. Counties shall not enter into any agreements or contracts to make payment to individual providers.

.2 County Responsibility

.21 The CRT counties shall directly input required data and initiate transactions into the system via terminals located in the county.

.22 The Paper counties shall input required data and initiate transactions on prescribed forms and submit those forms to the payrolling contractor.

.221 Exception: Special preauthorized transactions may be initiated by phone to the payrolling contractor. The prescribed document shall subsequently be sent from the payrolling contractor to the county confirming the transaction.

.23 For purposes of the payrolling system, the initial authorization period begins in the calendar month in which the first day of authorization occurs and continues until changed.

30-769 PAYROLLING FOR INDIVIDUAL PROVIDERS (Continued) **30-769**

.24 General Process

.241 The counties shall:

(a) Enter prescribed data on all recipients and providers, as defined in Section 30-767.13, into the payrolling system.

(b) Change data as necessary to ensure correct payment to the correct individual.

(c) Authorize the disbursement of all funds paid by the payrolling contractor by:

(1) Reviewing all time sheets prior to entry of time sheet data into the system to ensure consistency between hours reported and hours authorized.

(2) Reviewing any significant discrepancies between hours reported and hours authorized to determine the reason and take corrective action as indicated.

(3) Initiating special transactions as described in .25 below.

(d) Retain completed time sheets as required by Section 23-353 in such a manner that they are easily accessible for review.

(e) Respond to and resolve payment inquiries from recipients and providers. The payrolling contractor will provide all necessary information.

.25 Special Transaction

.251 Special transactions are used to handle situations which fall outside the normal payroll process. Counties shall be held responsible for closely monitoring and controlling the use of the following transactions.

.252 The county shall initiate emergency/supplemental checks for:

(a) Payments resulting from retroactive state hearing decisions.

(b) Payments resulting from prior underpayments.

(c) Payments in excess of the base rate as provided in Section 30-764.

30-769 PAYROLLING FOR INDIVIDUAL PROVIDERS (Continued) **30-769**

(d) Payments for severely impaired recipients in advance pay status who become eligible for payment between a pay cycle.

(e) Payments where the county finds that an emergency situation exists.

(f) Payments to counties for reimbursements of emergency checks as described in .26 below.

(g) Payments for other unusual situations not provided for by the regular payrolling process and where the county deems appropriate.

(h) Payments for time sheets submitted three or more months beyond the current payroll cycle.

.253 A request for a replacement check shall be made expeditiously by the county but no sooner than five (5) days from the date the original check should have been received.

.254 A void transaction shall be used:

(a) When a payroll check is returned to the payrolling contractor or county.

(b) When a payroll check is mutilated.

(c) When a payroll check is not in the possession of the county or the payrolling contractor.

.255 Adjustment transactions shall be used to make adjustments to tax records when any of the following occur:

(a) An overpayment.

(b) An underpayment.

(c) An incorrect deduction.

.26 County issued payments shall only be issued in cases of extreme emergency when the county finds that the emergency check procedure provided in .252 is not adequate.

30-769 PAYROLLING FOR INDIVIDUAL PROVIDERS (Continued) **30-769**

.261 The county shall issue checks for an amount not to exceed ninety (90%) percent of the amount the recipient/provider should receive.

.262 The county shall be reimbursed for payments made under .261 above by the payrolling contractor using the emergency/supplemental check transaction.

.263 The county shall not receive reimbursement until an emergency/ supplemental transaction has been initiated to pay the recipient/ provider the remaining balance.

.264 The county shall receive a time sheet before the transaction in .261 or .263 above shall occur. Exception: The county may issue a check prior to receipt of a time sheet for a severely impaired recipient who opted for advance pay.

.27 The counties shall be responsible for verifying eligibility of recipients for IHSS between January 1, 1978 and December 31, 1979 as needed for retroactive tax payments.

.28 The county shall ensure that all providers are informed of the requirements they must meet in order to be paid.

.3 The County Has The Sole Responsibility For Determining And Investigating Fraud And Forgery for Non-PCSP

.31 The county shall, with no effect on current county procedures:

.311 Identify suspected fraud cases;

.312 Determine if actual fraud exists;

.313 Take appropriate action as necessary.

.32 The county will be notified by the payrolling contractor if an original check has already been cashed when a replacement check is requested. The county shall then follow the applicable procedure in the user's manual.

.4 PCSP Fraud or Forgery

30-769 PAYROLLING FOR INDIVIDUAL PROVIDERS (Continued) **30-769**

HANDBOOK BEGINS HERE

.41 DHS regulation Section 50782 reads:

Fraud occurs if an overpayment occurs and the beneficiary or the person acting on the beneficiary's behalf willfully failed to report facts as specified in Section 50781(b) with the intention of deceiving the Department, the county department or the Social Security Administration for the purpose of obtaining Medi-Cal benefits to which the beneficiary was not entitled.

.42 If PCSP fraud or forgery occurs, DHS will follow the procedures cited in DHS regulation Section 50793.

HANDBOOK ENDS HERE

.5 Return Check Procedures

.51 Counties which receive a returned check from a provider or recipient shall follow the applicable procedures in the user's manual.

30-769 PAYROLLING FOR INDIVIDUAL PROVIDERS (Continued) **30-769**

.6 Refunds/Recoupment

.61 Counties which receive refunds or recoupments shall:

.611 Deposit the money received in a county account; and

.612 Send a monthly check to the payrolling contractor for the amount of refund/recoupment received during the previous month in accordance with applicable procedures in the User's Manual.

.7 Recipient Responsibility

.71 It is the responsibility of the recipient to report to social services staff accurately and completely all information necessary to complete the SOC 311.

.72 The recipient, within his/her physical, emotional, educational or other limitations, shall:

.721 Designate the authorized hours per provider within the total of the recipient's authorized hours.

.722 Designate each provider(s) portion of the share of cost.

.723 Sign and date the prescribed time sheet to:

(a) Verify payment of the share of cost to the appropriate provider(s).

(b) Verify that services authorized where rendered by the appropriate provider.

.724 Inform social services staff of any changes affecting the payrolling process.

.73 Payments for authorized services rendered shall be sent to the recipient's appropriate provider. The recipient shall not receive payment for services except as provided in .731 through .734 below.

.731 Severely impaired recipients as defined under Section 30-753, shall have the option of choosing to directly receive their payment at the beginning of each authorized month. Such payment shall be the net amount exclusive of the appropriate withholdings.

30-769 PAYROLLING FOR INDIVIDUAL PROVIDERS (Continued) **30-769**

.732 In direct payment cases, where a recipient is incapable of handling his/her financial and legal affairs and has a legal guardian or conservator, direct payment shall be made to the recipient's legal guardian or conservator at such person's request.

.733 Payment may be made to a recipient's guardian, conservator, substitute payee, or person designated by the recipient.

.734 When payment is made as a result of a state hearing decision.

.735 If the recipient is severely impaired he/she shall be notified in writing of the right to hire and pay his/her own provider, and to receive his/her monthly cash payment in advance.

.736 When direct payment is made to a recipient, guardian, conservator, or substitute payee, the provider shall be hired, supervised, and paid by such payee. In such cases, the recipient or the person authorized to act in the recipient's behalf shall insure that the services provider is capable of and is providing the services authorized.

.737 It shall be the responsibility of the severely impaired recipient, legal guardian or conservator who receives payment in advance to submit their provider's time sheets at the end of each authorized service month to the appropriate county social services office.

.8 Provider Benefits

.81 The department has elected to provide the worker's compensation coverage required by Welfare and Institutions Code Section 12302.2 through a single statewide insurance policy. Additional insurance coverage will not be reimbursed as an IHSS program cost.

.82 The department has elected to handle the payment of the unemployment insurance tax, unemployment disability insurance tax, and social security tax required by Welfare and Institutions Code Section 12302.2 through the payrolling system.

.83 The department has elected to require the payrolling contractor to deduct the employee's share of the following taxes from the payment to the provider or the recipient:

30-769 PAYROLLING FOR INDIVIDUAL PROVIDERS (Continued) **30-769**

.831 Social security.

.832 State disability insurance.

.84 The department has elected to deduct and transmit the state and federal income tax withholdings due on the provider's earnings for those providers who voluntarily request this service.

.9 Excessive Compensation

(See Section 30-769.91 (Handbook) for examples of excessive compensation)

HANDBOOK BEGINS HERE

.91 Excess compensation to an individual provider but is not necessarily limited to the following circumstances:

.911 The provider was paid for more hours than authorized or more hours than worked.

.912 The provider was paid at a higher hourly rate than appropriate.

.913 The share of cost withheld from provider's payment was less than the recipient affirms was paid to the provider.

HANDBOOK ENDS HERE

.92 All excess provider compensation is recoverable. The county shall demand repayment from the provider. The county shall be permitted to seek recovery of excess compensation by civil suit.

.93 Provider Fraud or Forgery

If the county suspects that excess provider payment occurred because of fraudulent devices of the provider, forgery, or collusion between the provider and the recipient, the county shall investigate the suspected fraud, forgery, or collusion. If the facts warrant prosecution and the county does not have an investigative unit, the county shall refer the matter directly to the county district attorney's office for investigation and possible prosecution.

NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Section 14132.95, Welfare and Institutions Code.

30-770 ELIGIBILITY STANDARDS 30-770

.1 Persons applying for IHSS under Sections 30-755.112, .113 and .114 shall meet the SSI/SSP eligibility standards except as modified by Section 30-755.1.

.2 Detailed eligibility standards shall be those located in 20 CFR Part 416, except as modified by IHSS regulations beginning with Section 30-750.

.3 Definitions.

.31 For the purposes of eligibility for IHSS, a child means an individual who is neither married nor the head of a household, and who is under the age of 18, or under the age of 22 and a student regularly attending a school, college, or university, or a course of vocational or technical training designed to prepare him/her for gainful employment.

.311 For the purposes of deeming for IHSS, a child means an individual who is neither married nor the head of a household, and who is under the age of 18.

.312 Regularly attending school means being enrolled in eight semester or quarterly hours weekly in a college or university, or 12 hours weekly in a secondary school. In a course of vocational or technical training, 15 clock hours weekly are required; without shop practice, at least 12 hours weekly are required.

.313 Eligible spouse means an aged, blind, or disabled individual who is the husband or wife of another aged, blind, or disabled individual who has not been living apart from such other aged, blind, or disabled individual for more than six months.

.4 Residency

.41 Residency in State Required

To be eligible for IHSS, an individual shall be a U.S. citizen, or an eligible alien pursuant to Welfare and Institutions Code Section 11104. The individual shall also be a California resident, physically residing in the state except for temporary absence as noted below in Sections 30-770.42 through .45, with the intention to continue residing here.

30-770 ELIGIBILITY STANDARDS (Continued) **30-770**

HANDBOOK BEGINS HERE

Welfare and Institutions Code Section 11104 states:

"Aliens shall be eligible for aid only to the extent permitted by federal law.

"An alien shall only be eligible for aid if the alien has been lawfully admitted for permanent residence, or is otherwise permanently residing in the United States under color of law. No aid shall be paid unless evidence as to eligible alien status is presented."

HANDBOOK ENDS HERE

.42 Physical Absence from the State

Physical absence from the state indicates a possible change of state residence. The county shall make inquiry of a recipient who has been continuously absent from the state for 30 days or longer in order to ascertain the recipient's intent to maintain California residency. If the inquiry establishes that the recipient is no longer a California resident, authorization for IHSS shall be discontinued.

.421 The county inquiry to the recipient will require the recipient to submit a written statement that:

(a) Declares his/her anticipated date of return to the state, or his/her intent not to return to the state;

(b) Declares his/her reason for continued absence from the state; and

(c) Provides needed information on his/her location and status of household arrangements.

.422 The county will include in the inquiry to the recipient a statement that his/her failure to respond to the inquiry by a specified date will result in his/her ineligibility and the discontinuation of IHSS.

30-770 ELIGIBILITY STANDARDS (Continued) **30-770**

.43 Evidence of Residence Intention

.431 The written statement of the recipient is acceptable to establish his/her intention and action on establishing residence unless the statement is inconsistent with the conduct of the person or with other information known to the county.

.432 If the recipient does not respond by the specified date to the inquiry of residence, it shall be presumed that he/she does not intend to maintain California residency, and authorization for IHSS shall be discontinued when the absence exceeds 60 days in accordance with regulations (Sections 30-759.7 and 10-116).

.433 If the recipient responds to the inquiry and advises the county that he/she does not intend to return to California, authorization for IHSS shall be discontinued in accordance with regulations.

.44 Absence from State for More than 60 Days

.441 If the recipient responds to the inquiry and advises the county that he/she intends to maintain his/her California residence, but he/she remains or has remained out of state for 60 days or longer, his/her continued absence is prima facie evidence of the recipient's intent to have changed his/her place of residence to a place outside of California, unless he/she is prevented by illness or other good cause from returning to the state at the end of 60 days. Such absence in itself is sufficient evidence to support a determination that the recipient has established residence outside of California. Therefore, his/her intent to return must be supported by one or a combination of the following:

(a) Family members with whom the recipient lived, currently live in California;

(b) The recipient has continued maintenance of his/her California housing arrangements (owned, leased, or rented);

(c) The recipient has employment or business interest in California;

(d) Any other act or combination of acts by the recipient which establishes his/her intent to reside in California.

30-770 ELIGIBILITY STANDARDS (Continued) **30-770**

.442 Even if the recipient's intent to reside in California is supported by .441 above, the following evidence shall be utilized to determine the recipient's intent to reside in California:

(a) The recipient has purchased or leased a place of residence out of state since leaving California;

(b) The recipient has been employed out-of-state since leaving California;

(c) The recipient has obtained an out-of-state motor vehicle driver's license after leaving California;

(d) The recipient has taken any other action which indicates his/her intent to establish residence outside of California.

HANDBOOK BEGINS HERE

.443 Welfare and Institutions Code Section 1110 states that if a recipient is prevented by illness or other good cause from returning to California at the end of 60 days, and has not by act or intent established residence elsewhere, he shall not be deemed to have lost his residence in this state. The following is added by Welfare and Institutions Code Section 11100.1(a):

For purposes of the In-Home Supportive Services Program ..."good cause," as defined in Section 11100, shall include, but is not limited to, the following:

(1) Outpatient medical treatment necessary to maintain the recipient's health where the medical treatment is not available in California.

(2) Short-term schooling or training necessary for the recipient to obtain self-sufficiency where training which would achieve that objective is not available or accessible in California.

(3) Court-issued subpoena or summons.

HANDBOOK ENDS HERE

30-770 ELIGIBILITY STANDARDS (Continued) **30-770**

(a) For outpatient medical treatment out of state, good cause for continuing to receive benefits while absent from the state for more than 60 days shall also include the situation where the medical treatment is not accessible in California.

(b) Accessible in these regulations means attainable for the recipient in California, given the dysfunctioning and needs of the recipient.

(c) Other good cause reasons for continuing to receive IHSS benefits while absent from the state for over 60 days shall be consistent with the good cause reasons contained in Welfare and Institutions Code Section 11100.1.

(1) The situation shall be of an urgent or emergency nature:

(2) The service required shall be necessary to maintain the physical or psychological health of the recipient:

(3) The services required or like services shall be either not available or not accessible in California.

.444 A recipient absent from California for more than 60 days and who is not prevented from returning to this state because of illness or other good cause shall have his/her authorization for IHSS discontinued in accordance with regulations.

.45 Absence from the State Exceeding Six Months

.451 Authorization for IHSS shall be suspended for any recipient who leaves the state and who remains absent from the state for a period which exceeds six months, notwithstanding the fact that the recipient has continued to receive IHSS benefits beyond 60 days because he/she was prevented from returning to the state due to illness or other good cause, as specified in Sections 30-770.43 and .44. Suspension of benefits will be in accordance with notice of Action regulations contained in Sections 30-759.7 and 10-116.

30-770 ELIGIBILITY STANDARDS (Continued) **30-770**

.452 In-Home Supportive Services shall not be resumed until the recipient, upon returning to the state, requests a reassessment of need from the county, and the reassessment has been completed in accordance with regulations (Section 30-763).

.46 Outside the United States While Absent from the State

.461 In-Home Supportive Services shall be discontinued for any recipient who is outside the United States for all of any month, or for 30 days in a row, as such an individual is no longer eligible to receive SSI/SSP. Discontinuation of benefits will be in accordance with notice of action regulations.

(a) Upon the individual's return to the United States, and upon his/her reestablishment as an SSI/SSP recipient, an SSI/SSP eligible recipient, or an individual who would be eligible for SSI/SSP except for excess income, he/she may again apply for IHSS benefits. The county shall redetermine IHSS eligibility and perform a needs assessment based on current circumstances.

(b) "United States" includes the 50 states, the District of Columbia, and the Northern Mariana Islands.

.47 Continuation of IHSS While Absent from the State

.471 When the county has determined that the recipient is entitled to the continuation of IHSS benefits while absent from the state (the recipient is absent from the state for 60 or more days and is prevented from returning due to illness or other good cause, as determined in Sections 30-770.42, .43, and .44), the following apply:

(a) The recipient shall continue to receive the same number of hours of IHSS that were authorized prior to his/her temporary absence. This level of authorization will continue until a reassessment is required.

(b) The recipient's out-of-state individual provider (IP) shall be reimbursed at the county's lowest current IP base rate.

(c) The recipient must continue to mail time sheets to the county as required by regulations.

30-771 LINKAGE 30-771

.1 Aged - An aged individual shall be considered to be one who is 65 years of age or older.

.2 Blindness - An individual shall be considered to be blind for purposes of IHSS if:

.21 He/she has central visual acuity of 20/200 or less in the better eye with use of a correcting lens. An eye which is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees shall be considered as having a central visual acuity of 20/200 or less.

.22 He/she is blind as defined under the state plan approved under Title X as in effect for October 1972 and received aid under such plan on the basis of blindness for December 1973, provided that he/she is continuously so defined.

.3 Disability - An individual shall be considered to be disabled for the purposes of IHSS if one of the following applies:

.31 He/she is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which has lasted or can be expected to last for a continuous period of not less than 12 months.

.32 In the case of a child under the age of 18, if he/she suffers from any medically determinable physical or mental impairment of comparable severity.

.33 He/she is permanently and totally disabled as defined under a state plan approved under Title XIV as in effect for October 1972 and received aid under such plan on the basis of disability for at least one month prior to July 1973 and for December 1973, provided that he/she is continuously disabled as so defined.

.4 Additional criteria regarding aged, blindness and disabled eligibility shall be applied as outlined in 20 CFR 416, Subpart 1.

30-773 RESOURCES 30-773

.1 All resources, both liquid and non-liquid, shall be evaluated based upon their equity value with the exception of automobiles, which shall be evaluated as specified in .6(c) below.

.2 Each aged, blind, or disabled individual whose eligibility for aid commenced on or after January 1, 1974 may have countable resources not in excess of $1,500 in value and be eligible.

.3 An individual who is living with either an eligible or ineligible spouse may have countable resources not in excess of $2,250 in value and remain eligible.

.31 The $2,250 limitation includes the resources of such spouse.

.4 The resources of a recipient child who is living with his/her parent, parents, or parent and spouse of parent, shall be deemed to include that portion of the countable resources of his/her parent(s) and spouse of parent which exceeds $1,500 in value in the case of one parent, or $2,250 in value in the case of two parents or parents or parent and spouse.

.41 For the purposes of this section, a recipient child is an unmarried person under the age of 18.

.5 Individuals receiving AB, ATD, or OAS in December 1973, including individuals who applied for aid in December 1973 and met all the conditions of eligibility for payment in that month, shall continue to be subject to the property limitations in effect in December 1973 unless the recipient would be advantaged by the regulations regarding resource limitations currently in effect.

.6 In determining the countable resources of an individual, and spouse if any, the following items shall be excluded:

(a) The home.

(b) Household goods and personal effects to the extent that the combined equity value does not exceed $2,000. Where the equity value exceeds $2,000, the excess shall be counted toward the resources limitation.

30-773 RESOURCES (Continued) **30-773**

(c) Automobiles, as defined in 20 CFR 416, Subpart L.

(1) One automobile shall be totally excluded regardless of its value if, for the individual or a member of the individual's household, one of the following applies:

(A) It is necessary for employment.

(B) It is necessary for transportation to a site for medical treatment of a specific ongoing medical problem.

(C) It is modified for operation by or transportation of a handicapped person.

(2) If no automobile is excluded under (1) above, one automobile shall be excluded from counting as a resource to the extent its current market value does not exceed $4,500.

(A) If the market value exceeds $4,500, the excess shall be counted against the resources limitation.

(3) When the recipient or spouse has more than one automobile, such additional automobile(s) shall be treated as non-liquid resources and shall be counted to the extent of their equity value unless they are the property of a trade or business, or are nonbusiness properties which are essential to the means of self-support, as provided in (d) and (e) below.

(d) Property of a trade or business which is essential to the means of self-support, as provided in federal guidelines.

(e) Nonbusiness property which is essential to the means of self-support, as provided in federal guidelines.

(f) Resources of a blind or disabled individual which are necessary to fulfill a plan for achieving self-support as described in Section 30-775.436.

(g) Life insurance if the face value does not exceed $1,500. If the face value exceeds $1,500, the entire cash surrender value of the insurance shall be counted toward the resources limitation. Term insurance and burial insurance shall be totally excluded.

30-773 RESOURCES (Continued) **30-773**

(h) Any other resources deemed excludable by the Secretary of Health and Human Services under the provisions of Title XVI of the Social Security Act.

(i) Restricted allotted land owned by an enrolled member of an Indian tribe.

(j) Per capita payments distributed pursuant to any judgment of the Indian Claims Commission or the Court of Claims in favor of any Indian tribe as specified in Public Law 93-134.

(k) Shares of stock and money payments made to Alaskan Natives under the Alaskan Native Claims Settlement Act provided that the payments or stock remain separately identifiable and are not commingled with nonexempt resources. Any property obtained from stock investments under the Act shall not be exempt.

(l) Tax rebates, credits or similar temporary tax relief measures which state or federal laws specifically exclude from consideration as a personal property resource. The specific rebates and credits listed in Section 30-775.42(a) shall also be exempt as property provided that the monies retained are not commingled and are separately identifiable as a proportionate share of the recipient's property.

(m) Otherwise countable resources shall be exempt up to the amount of benefits paid on behalf of the applicant/recipient for long-term care services under a State certified long-term care insurance policy or certificate, certified by the State to provide such exemption.

(1) Any income generated by such exempt property is countable as income in the month received. See Section 30-775.

30-773 RESOURCES (Continued) **30-773**

HANDBOOK BEGINS HERE

(A) An example of income generated by such exempt property would be rental income generated by an exempt resource.

HANDBOOK ENDS HERE

(2) The burden shall be rebuttably presumed to have been met if the applicant/recipient presents a "SERVICE SUMMARY" signed by a representative of the insurance company verifying that the applicant/recipient is a holder of an insurance policy or certificate certified by the State to provide the exemption, and specifying the total amount of qualifying benefits paid out under the policy to date.

(3) The amount of the qualifying benefits stated to have been paid in the "SERVICE SUMMARY" referred to in Section 30-773.6(m)(2) shall be the amount of the exemption to which the applicant/recipient is entitled.

(4) If the statement by the insurance company is found to be erroneous, the county shall promptly notify the California Department of Health Services.

(5) If the statement by the insurance company is such that the county cannot determine whether the applicant/recipient is covered by a qualifying policy or the amount of the benefits paid out on behalf of the beneficiary, the county shall deny the exemption. When an exemption is denied, the county shall refer the recipient to the California Department of Health Services for assistance and shall notify the California Department of Health Services of the reasons for this determination.

30-773 RESOURCES (Continued) **30-773**

HANDBOOK BEGINS HERE

(6) This is a sample of a SERVICE SUMMARY as referred to in Section 30-773.6(m)(2). The service summary is a form required by the California Department of Health Services. (See Title 22, Sections 58032 and 58080.)

(Company letterhead with company seal)

Name of Insured Date of Birth

Social Security Number

Address of Insured

Policy Number Issue Date

Insurance Company

SERVICE SUMMARY:	The Total Amount of Benefits Paid for Long-Term Care Services Countable toward the Medi-Cal Property Exemption	$91,000

To the Insured: This summary provides you with the total amount of insurance payments that count towards the Medi-Cal Property Exemption to be applied in determining eligibility for the State of California's Medicaid (Medi-Cal) Program. Please examine this summary and carefully compare your current asset total with the amount. If the amount of your Medi-Cal Property exemption is close to the amount of the assets you currently have, you may be eligible for the Medi-Cal Program. It is your responsibility to make application to the county (usually the Department of Social Services) for such eligibility. At the time of your application, a determination will be made whether and when you are eligible. (Please note: You may have assets, in addition to the Property Exemption listed above, that are exempted from the determination of Medi-Cal eligibility.)

HANDBOOK CONTINUES

30-773 RESOURCES (Continued) **30-773**

HANDBOOK CONTINUES

To the County: This summary verifies that the amount indicated with the label "SERVICE SUMMARY" was paid by (company name) for long-term care services as defined in California Code of Regulations, Title 22, Section 58023 on behalf of the person whose name appears as the "Name of Insured" above. This amount is exempt from the determination of Medi-Cal eligibility pursuant to California Code of Regulations, Title 22, Section 50453.7. If such person is found eligible for Medi-Cal by applying the Medi-Cal Property Exemption amount reported in this summary and after receiving Medi-Cal services is found to be ineligible solely by reason of errors in this summary, the Department of Health Services may recover from (company name) the amount of service payments as provided in California Code of Regulations, Title 22, Section 58082(e).

(Name and Title) (date)

(Company Name)

HANDBOOK ENDS HERE

.7 Disposition of Resources.

.71 Although an individual's resources, including those of his/her spouse, exceed the limits imposed in .2 through .4 above, he/she shall be eligible for IHSS during the period of disposition of such excess resources provided that he/she meets other eligibility criteria, including those specified in this section.

.711 In no event shall total countable resources exceed $3,000 in value for an individual, or $4,500 in value for an individual and spouse. Total countable liquid resources shall not exceed $714 for an individual or $1,071 for an individual and spouse.

.72 The applicant or recipient shall agree in writing to dispose of the excess resources within the time limit specified in .74 below and to repay any overpayments with the proceeds of the disposition.

30-773 RESOURCES (Continued) **30-773**

.73 During the period that the excess property is held and is under disposition, in accordance with the individual's agreement to dispose of the property, any IHSS payments made shall be considered to be overpayments.

.731 The net proceeds from the disposition of the excess property shall be considered to be available for liquidation of overpayments occurring during the disposition period in accordance with Section 30-768.3.

.74 The disposition of the excess property shall be accomplished within a six-month period in the case of real property and within three months in the case of personal property.

.741 The time period shall begin on the date the agreement is signed by the individual.

(a) In the case of a disabled individual, the time period shall begin on the date of the disability determination.

.742 The time limits may be extended another three months where it is found that the individual had "good cause" for failing to dispose of the property within the original time period.

(a) "Good cause" shall exist if, despite reasonable and diligent effort on his/her part, he/she was prevented by circumstances beyond his/her control from disposing of the property.

NOTE: Authority cited: Section 22009(b), Welfare and Institutions Code. Reference: Section 22004, Welfare and Institutions Code.

30-775 INCOME **30-775**

.1 Income means the money or other gain periodically received by an individual for labor or service, or from property, investment, operations, etc. Income may be in the form of cash, including checks and money orders; in-kind items; real property; or personal services.

.11 When the item of receipt is not in the form of cash, the cash equivalent shall be determined.

.12 An individual's or individual and eligible spouse's income shall include all of his/her or their income in cash or in-kind, both earned and unearned.

30-775 INCOME (Continued) **30-775**

.13 An individual's income shall also include those amounts of income of his/her eligible spouse, or, if the individual is a child as defined in Section 30-770.3, of his/her parent and parent's spouse residing in the same household.

.14 If income after applying the allowable disregards or exclusions exceeds the appropriate SSI/SSP benefit level, the excess shall be applied to the cost of IHSS.

.2 Earned Income

.21 Earned income means:

.211 Gross wages.

.212 Net earnings from self-employment.

(a) Net earnings shall be determined by deducting from gross earnings from self-employment all ordinary and necessary business expenses. Principal payments on encumbrances and personal income taxes shall not be considered expenses. Schedules attached to Form 1040 of the IRS for various types of self-employment may be used to verify allowable expenses.

.213 Those amounts of countable earned income deemed to be available to the individual from the income of his/her ineligible spouse, or parent(s) in the case of a recipient child.

(a) When a parent and recipient child live in a household with the parent's spouse, who is not the parent of the child, the income of the parent's spouse shall also be deemed to the child.

(b) Deeming procedures shall conform to those specified in 20 CFR 416.1185, as set forth on the form(s) developed and approved by the department.

.3 Unearned Income.

.31 Unearned income means all other available income.

.32 In evaluating the amount of unearned income which is available to the individual, consideration shall be given to any necessary costs involved in obtaining or securing the income.

30-775 INCOME 30-775

.33 Unearned income includes, but is not limited to, the following:

.331 Support and maintenance furnished in cash or in-kind.

(a) A person who meets the criteria in Section 46-325.51 shall have the household of another SSI/SSP benefit level used to compute share of cost in lieu of counting the support and maintenance as unearned income.

(1) A person subject to the above procedure may still be eligible for IHSS if living in his/her own home as defined in Section 30-753.

.332 Any payments received as an annuity, pension, retirement, disability, OASDI, unemployment, veteran's or workmen's compensation benefit.

.333 Prizes and awards.

.334 Gifts, support and alimony payments, and inheritances.

.335 Rents, dividends, interests, and royalties.

.336 The proceeds of any life insurance policy to the extent that they exceed the amount expended by the beneficiary for purposes of the insured individual's last illness and burial expenses or $1,500, whichever is less.

.337 Those amounts of countable unearned income deemed to be available to the individual from the income of his/her ineligible spouse or parent(s) in the case of a recipient child.

(a) When a parent and recipient child live in a household with the parent's spouse, who is not the parent of the child, the income of the parent's spouse shall also be deemed to the child.

(b) Deeming procedures shall conform to those specified in 20 CFR 416.1185, as set forth on the form(s) developed and approved by the department.

30-775 INCOME (Continued) **30-775**

.4 Payments Excluded or Disregarded in Considering Income.

.41 In determining the eligibility for and amount of IHSS, certain payments received or portions thereof shall not be counted as income to the individual and eligible spouse. These exclusions shall also apply in deeming from an ineligible spouse or, in the case of a recipient child, the ineligible parent(s).

.42 The following items shall be excluded from consideration as income:

(a) Refunds, credits and rebates of taxes.

(1) Refunds of taxes paid on real property or purchased food received from any public agency, or renter's credit payments, or special tax credit payments for renters 62 years and older.

(2) Tax rebates, credits or similar temporary tax relief measures which state or federal law specifically exclude from consideration as income.

(b) Assistance based on need.

(1) Payments which are composed entirely of state or local government funds, when made under a program using income level as a criteria for determining the amount of such payment.

(A) When federal or nonpublic monies are included in the assistance payment, such payments shall be countable, including AFDC payments to federally eligible persons, which are countable on a dollar-for-dollar basis related to the recipient's pro rata share.

(c) Grants, scholarships, and fellowships.

(1) Any portion of any grant, scholarship, or fellowship received, used or to be used in paying tuition and fees at any educational institution, including technical or vocational.

30-775 INCOME (Continued) **30-775**

(d) Home produce.

(1) The value of agricultural products which are not raised in connection with a trade or business and are utilized for consumption by the household.

(A) If the produce is sold, the net earnings shall be countable as earned income.

(e) Foster care payments.

(1) Payments for the foster care of a child who is not an eligible individual but who resides in the same home as such individual and was placed there by a public or nonprofit agency.

(f) Support payment from an absent parent.

(1) One-third of any payment received from an absent parent for an eligible individual who is a child as defined in Section 30-770.3.

(A) The remainder shall be countable as unearned income.

(g) Readers and educational scholarships for the blind.

(1) Funds, not available to meet basic needs, awarded for readers and educational scholarships by a high school, institution of higher learning, or a vocational or technical training institution to a recipient due to his/her blindness while he/she is regularly attending any public school or any institution of higher learning in this state.

(h) Vendor payments.

(1) Payments made from any source to a vendor in order to meet the needs of the recipient for medical or social services, as determined by the county welfare department. When the vendor is the recipient's spouse, the provisions of .213 above shall apply.

30-775 INCOME (Continued) **30-775**

(i) CETA incentive payments.

(1) Up to $30 per week of the incentive allowances made to trainees under Title I of the Comprehensive Employment and Training Act (CETA).

(A) This exemption shall apply to any CETA trainee whose needs or income are taken into account in determining the amount of public assistance payments to himself/herself or others.

(B) This exemption shall not apply to wages or other training allowances under the Act.

(j) Payments to Indians.

(1) Per capita payments distributed pursuant to any judgment of the Indian Claims Commission or the Court of Claims in favor of any Indian tribe as specified in Public Law 93-134.

(A) This exemption shall apply to anyone whose income is taken into account to determine the eligibility or grant of a recipient.

(k) Payments made to Alaskan Natives.

(1) Shares of stock and money payments made to Alaskan Natives under the Alaskan Native Claims Settlement Act.

(A) Income resulting directly from stock investments under the Act shall not be exempt.

(l) Supportive services payments.

(1) Payments for supportive services or reimbursement of out-of-pocket expenses made to persons serving in the Service Corps of Retired Executives (SCORE) and the Active Corps of Executives (ACE) pursuant to Section 418 of Public Law 93-113.

(A) This exemption shall apply to all persons whose income is taken into account in determining the amount of the IHSS payment.

30-775 INCOME (Continued) **30-775**

(m) Domestic Volunteer payments.

(1) Payments made under the Domestic Volunteer Services Act of 1973 to welfare recipients who are VISTA volunteers.

(n) Supplemental food assistance.

(1) The value of supplemental food assistance received under the Child Nutrition Act (WIC) and the National School Lunch Act, as specified in Public Laws 92-433 and 93-150.

(o) Energy assistance allowances.

(1) Payments or allowances made under any federal, state or local laws for the purpose of energy assistance, e.g., Low Income Energy Assistance Program (EAP), Energy Crisis Assistance Program (ECAP), and Crisis Intervention Programs (CIP) payments.

(A) Such payments or allowances shall be clearly identified as energy assistance by the legislative body authorizing the program or providing the funds.

.43 The following disregards shall be applied in the order listed below:

.431 Infrequent or irregular income.

(a) Unearned income.

(1) Unearned income which does not exceed $60 per quarter and is received not more than once per quarter or cannot be reasonably anticipated.

(b) Earned income.

(1) Earned income which does not exceed $30 per quarter and is received not more than once per quarter or cannot be reasonably anticipated.

.432 Student exemption.

(a) Up to $1,200 per calendar quarter of the earned income of the recipient who is a child and a student, but in no instance more than $1,620 per calendar year.

30-775 INCOME (Continued) **30-775**

.433 The first $20 per month.

(a) The first $20 of earned or unearned income per month not disregarded above. If the eligible individual or individual and eligible spouse has:

(1) Only earned income, the disregard shall be applied to that income.

(2) Only unearned income, the disregard shall be applied to that income.

(3) Both types of income, the disregard shall first be applied toward the unearned income, and any amount of the disregard remaining shall be applied to the earned income.

.434 Earned income.

(a) The first $65 per month of earned income not disregarded above plus one-half of the remainder.

.435 Work expenses of the blind.

(a) Earned income not disregarded above of a blind individual in the amount of ordinary and necessary expenses related to work activity, and only to the extent that they are paid or to be paid. Broad categories of expenses shall include but not be limited to the following:

(1) Transportation to and from work.

(2) Job performance.

(3) Qualification for promotion.

.436 Income necessary to achieve self-support.

(a) Earned or unearned income not disregarded above and received by an individual who is blind or disabled as defined in Sections 30-771.2 and .3 to the extent that such income is needed to implement a plan of self-support.

30-775 INCOME (Continued) **30-775**

(1) Such plan shall be in writing and shall be approved by the United States Social Security Administration (SSA) unless a state-approved plan is still in effect when the blind or disabled individual becomes eligible for IHSS.

(2) The plan shall contain the following elements:

(A) Specific savings and/or disbursement goals for a designated occupational objective.

(B) Identification and segregation of such money and other resources as are being accumulated and conserved toward this goal.

.437 Income exclusions for certain blind individuals.

(a) For an individual who is blind as determined under the state plan approved until Title X as in effect in October 1972, and who received assistance under such plan in December 1973, an amount equal to the greater of the following:

(1) The maximum amount of any earned or unearned income which could have been disregarded under the state plan as in effect in October 1972; or

(2) The amount which would be required to be disregarded under .4 above without application of this subsection.

30-776 PROVIDER IDENTIFICATION **30-776**

.1 Proof of provider identification shall be required pursuant to Welfare and Institutions Code Section 12306.5.

30-776 PROVIDER IDENTIFICATION (Continued) **30-776**

HANDBOOK BEGINS HERE

Welfare and Institutions Code Section 12306.5 states that any public or private agency, including a contractor as defined in Welfare and Institutions Code Section 12302.1, who maintains a list or registry of prospective In-Home Supportive Services providers shall require proof of identification from a prospective provider prior to placing the prospective provider on a list or registry or supplying a name from the list or registry to an applicant for, or recipient of, In-Home Supportive Services.

HANDBOOK ENDS HERE

.11 Proof of identification shall not be required for prospective providers to remain on a list or registry that existed before April 1, 1988. However, proof of identification shall be required prior to providing those prospective providers' names to an applicant or recipient of In-Home Supportive Services, or prior to providing the names of any prospective providers where proof of identification has not been established.

.12 Proof of identification shall include, but is not limited to, one of the following:

.121 A positive photograph identification from a government source, such as:

(a) a valid California driver's license;

(b) a valid identification card issued by a government agency; or

(c) a valid military identification card.

.122 A valid student identification card issued by an accredited college or university.

30-780 PERSONAL CARE SERVICES PROGRAM (PCSP) ELIGIBILITY 30-780

HANDBOOK BEGINS HERE

.1 Scope of Services

DHS regulation Section 51183 reads:

Personal Care Services.

Personal care services include (a) personal care services and (b) ancillary services prescribed in accordance with a plan of treatment.

(a) Personal care services include:

(1) Assisting with ambulation, including walking or moving around (i.e. wheelchair) inside the home, changing locations in a room, moving from room to room to gain access for the purpose of engaging in other activities. Ambulation does not include movement solely for the purpose of exercise.

(2) Bathing and grooming including cleaning the body using a tub, shower or sponge bath, including getting a basin of water, managing faucets, getting in and out of tub, or shower, reaching head and body parts for soaping, rinsing, and drying. Grooming includes hair combing and brushing, shampooing, oral hygiene, shaving and fingernail and toenail care.

(3) Dressing includes putting on and taking off, fastening and unfastening garments and undergarments, and special devices such as back or leg braces, corsets, elastic stockings/garments and artificial limbs or splints.

(4) Bowel, bladder and menstrual care including assisting the person on and off toilet or commode and emptying commode, managing clothing and wiping and cleaning body after toileting, assistance with using and emptying bedpans, ostomy and/or catheter receptacles and urinals, application of diapers and disposable barrier pads.

HANDBOOK CONTINUES

30-780 PERSONAL CARE SERVICES PROGRAM (PCSP) ELIGIBILITY 30-780
(Continued)

HANDBOOK CONTINUES

(5) Repositioning, transfer, skin care, and range of motion exercises.

(A) Includes moving from one sitting or lying position to another sitting or lying position; e.g., from bed to or from a wheelchair, chair, or sofa, and the like, coming to a standing position and/or rubbing skin and repositioning to promote circulation and prevent skin breakdown. However, if decubiti have developed, the need for skin and wound care is a paramedical service.

(B) Such exercises shall include the carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function, improve gait, maintain strength, or endurance; passive exercises to maintain range of motion in paralyzed extremities; and assistive walking.

(6) Feeding, hydration assistance including reaching for, picking up, grasping utensil and cup; getting food on utensil, bringing food, utensil, cup to mouth, manupulating food on plate. Cleaning face and hands as necessary following meal.

(7) Assistance with self-administration of medications. Assistance with self-administration of medications consists of reminding the beneficiary to take prescribed and/or over-the-counter medications when they are to be taken and setting up Medi-sets.

(8) Respiration limited to nonmedical services such as assistance with self-administration of oxygen, assistance in the use of a nebulizer, and cleaning oxygen equipment.

(9) Paramedical services are defined in Welfare and Institutions Code Section 12300.1 as follows:

(A) Paramedical services include the administration of medications, puncturing the skin or inserting a medical device into a body orifice, activities requiring sterile procedures, or other activities requiring judgment based on training given by a licensed health care professional.

HANDBOOK CONTINUES

30-780 PERSONAL CARE SERVICES PROGRAM (PCSP) ELIGIBILITY 30-780
(Continued)

HANDBOOK CONTINUES

(B) Paramedical services are activities which persons could perform for themselves but for their functional limitations.

(C) Paramedical services are activities which, due to the beneficiary's physical or mental condition, are necessary to maintain the beneficiary's health.

(b) Ancillary services are subject to time per task guidelines when established in Sections 30-758 and 30-763.235(b) and 30-763.24 of the Department of Social Services' Manual of Policies and Procedures and are limited to the following:

(1) Domestic services are limited to the following:

(A) Sweeping, vacuuming, washing and waxing of floor surfaces.

(B) Washing kitchen counters and sinks.

(C) Storing food and supplies.

(D) Taking out the garbage.

(E) Dusting and picking up.

(F) Cleaning oven and stove.

(G) Cleaning and defrosting refrigerator.

(H) Bringing in fuel for heating or cooking purposes from a fuel bin in the yard.

(I) Changing bed linen.

(J) Miscellaneous domestic services (e.g., changing light bulbs and wheelchair cleaning, and changing and recharging wheelchair batteries) when the service is identified and documented by the case worker as necessary for the beneficiary to remain safely in his/her home.

HANDBOOK CONTINUES

30-780 PERSONAL CARE SERVICES PROGRAM (PCSP) ELIGIBILITY 30-780
(Continued)

HANDBOOK CONTINUES

(2) Laundry services include washing and drying laundry, and is limited to sorting, manipulating soap containers, reaching into machines, handling wet laundry, operating machine controls, hanging laundry to dry if dryer is not routinely used, mending, or ironing, folding, and storing clothing on shelves, in closets or in drawers.

(3) Reasonable food shopping and errands limited to the nearest available stores or other facilities consistent with the beneficiary's economy and needs; compiling a list, bending, reaching, and lifting, managing cart or basket, identifying items needed, putting items away, phoning in and picking up prescriptions, and buying clothing.

(4) Meal preparation and cleanup including planning menus; e.g., washing, peeling and slicing vegetables; opening packages, cans and bags, mixing ingredients; lifting pots and pans; reheating food, cooking and safely operating stove, setting the table and serving the meals; cutting the food into bite-size pieces; washing and drying dishes, and putting them away.

(5) Assistance by the provider is available for accompaniment when the beneficiary's presence is required at the destination and such assistance is necessary to accomplish the travel limited to:

(A) Accompaniment to and from appointments with physicians, dentists and other health practitioners. This accompaniment shall be authorized only after staff of the designated county department has determined that no other Medi-Cal service will provide transportation in the specific case.

(B) Accompaniment to the site where alternative resources provide in-home supportive services to the beneficiary in lieu of IHSS. This accompaniment shall be authorized only after staff of the designated county department have determined that neither accompaniment nor transportation is available by the program.

HANDBOOK CONTINUES

30-780 PERSONAL CARE SERVICES PROGRAM (PCSP) ELIGIBILITY 30-780
(Continued)

HANDBOOK CONTINUES

(6) Heavy Cleaning which involves thorough cleaning of the home to remove hazardous debris or dirt.

(7) Yard hazard abatement which is light work in the yard which may be authorized for:

(A) removal of high grass or weeds and rubbish when this constitutes a fire hazard.

(B) removal of ice, snow or other hazardous substances from entrances and essential walkways when access to the home is hazardous.

(c) Ancillary services may not be provided separately from personal care services listed in subsection (a) above.

.2 Personal Care Services Program Tasks

DHS regulation Section 51350 reads:

Personal Care Services.

(a) Personal care services as specified in Section 51183 are provided when authorized by the staff of a designated county department based on the state approved Uniformity Assessment tool. To the extent not inconsistent with statutes and regulations governing the Medi-Cal program, the needs assessment process shall be governed by the Department of Social Services' Manual of Policies and Procedures Sections 30-760, 30-761, and 30-763.

(b) Personal care services may be provided only to a categorically needy beneficiary as defined in Welfare and Institutions Code, Section 14050.1, who has a chronic, disabling condition that causes functional impairment that is expected to last at least 12 consecutive months or that is expected to result in death within 12 months and who is unable to remain safely at home without the services. The services shall be provided in the beneficiary's home or other locations as may be authorized by the Director subject to federal approval. Personal care services authorized shall not exceed 283 hours in a calendar month.

HANDBOOK CONTINUES

30-780 PERSONAL CARE SERVICES PROGRAM (PCSP) ELIGIBILITY 30-780
(Continued)

HANDBOOK CONTINUES

(c) Personal care services will be prescribed by a physician. The beneficiary's medical necessity for personal care shall be certified by a licensed physician. Physician certification shall be done annually.

(d) Registered nurse supervision consists of review of the service plan and provision of supportive intervention. The nurse shall review each case record at least every twelve months. The nurse shall make home visits to evaluate the beneficiary's condition and the effectiveness of personal care services based on review of the case record or whenever determined as necessary by staff of a designated county department. If appropriate, the nurse shall arrange for medical follow-up. All nurse supervision activities shall be documented and signed in the case record of the beneficiary.

(e) Paramedical services when included in the personal care plan of treatment must be ordered by a licensed health professional lawfully authorized by the State. The order shall include a statement of informed consent saying that the beneficiary has been informed of the potential risks arising from receipt of such services. The statement of informed consent shall be signed and dated by the beneficiary, the personal representative of the beneficiary, or in the case of a minor, the legal parent or guardian.

(f) Grooming shall exclude cutting with scissors or clipping toenails.

(g) Menstrual care is limited to external application of sanitary napkin and cleaning. Catheter insertion, ostomy irrigation and bowel program are not bowel or bladder care but paramedical.

(h) Repositioning, transfer skin care, and range of motion exercises have the following limitations:

(1) Includes moving from one sitting or lying position to another sitting or lying position; e.g., from bed to or from a wheelchair, or sofa, coming to a standing position and/or rubbing skin and repositioning to promote circulation and prevent skin breakdown. However, if decubiti have developed, the need for skin and wound care is a paramedical service.

HANDBOOK CONTINUES

30-780 PERSONAL CARE SERVICES PROGRAM (PCSP) ELIGIBILITY 30-780
(Continued)

HANDBOOK CONTINUES

(2) Range of motion exercises shall be limited to the general supervision of exercises which have been taught to the beneficiary by a licensed therapist or other health care professional to restore mobility restricted because of the injury, disuse or disease. Range of motion exercises shall be limited to maintenance therapy when the specialized knowledge or judgment of a qualified therapist is not required and the exercises are consistent with the beneficiary's capacity and tolerance. Such exercises shall include the carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function, improve gait, maintain strength, or endurance; passive exercises to maintain range of motion in paralyzed extremities; and assistive walking.

.3 Personal Care Services Program Required Documentation

DHS regulation Section 51476.2 reads:

Personal Care Services Records.

Each county shall keep, maintain, and have readily retrievable, such records as are necessary to fully disclose the type and extent of personal care services provided to a Medi-Cal beneficiary. Records shall be made at or near the time the service is rendered or the assessment or other activity is performed. Such records shall include, but not be limited to the following:

(a) Time sheets

(b) Assessment forms and notes

(c) All service records, care plans, and orders/prescriptions ordering personal care.

HANDBOOK ENDS HERE

30-780 PERSONAL CARE SERVICES PROGRAM (PCSP) ELIGIBILITY 30-780
(Continued)

.4 Eligibility for PCSP shall be limited to those IHSS recipients who do not receive IHSS advance payment as specified in Section 30-769.731.

NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Section 14132.95, Welfare and Institutions Code; and the State Plan Amendment, approved pursuant to Section 14132.95(b), Welfare and Institutions Code.

TABLE OF CONTENTS

CHAPTER 30-800 SERVICE PROGRAM NO. 8: PROTECTIVE SERVICES FOR ADULTS

CHAPTER 30-800 SERVICE PROGRAM NO. 8: PROTECTIVE SERVICES FOR ADULTS

30-800 GENERAL 30-800

.1 Services provided under this program shall be directed only at Goal 3.

30-802 DEFINITIONS 30-802

.1 **"Protective services for adults"** means those activities, resources and support provided by social services staff to prevent or remedy danger to adults who are:

.11 Unable to protect their own interests.

.12 Harmed, threatened with harm, or caused physical or mental injury as a result of action or inaction by another person, or their own actions, due to ignorance, illiteracy, incompetence, or poor health.

.13 Neglected or abused by others.

.14 Lacking in necessary food, shelter, or clothing.

.15 Deprived of entitlement due them.

.16 Exploited of their income or resources.

30-810 ELIGIBILITY 30-810

.1 Any adult shall be eligible for this service.

.2 Any report or referral containing any allegation of danger to an adult arising from the conditions specified in .211 through .216 below shall create a presumption of need for the services of this program, and shall be investigated promptly.

.21 Need for protective services shall be deemed to be present in the case of any adult who is:

.211 Living in conditions which present a health or safety hazard.

.212 Being deprived of necessary food, clothing, or shelter due to inability to manage, or to abuse, neglect, or exploitation by others.

.213 Not obtaining or utilizing necessary medical or psychiatric care.

.214 Unable to perform activities of daily living in his/her own home.

.215 Unable to arrange for necessary out-of-home care.

.216 In any other danger specified in Sections 30-802.11 through .16.